737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
Phone: (808) 591-0088
Toll-Free: (800) 621-6998
Fax: (808) 535-8363

HMAA USE ONLY	
Policy #	Div #

Business Application

Please print in **black ink** or complete online at www.hmaa.com

REV: 02/11

Failure to answer **every** question may result in delayed coverage.
Note: Previous versions of this form are not accepted.

Business Information

Business Name as it appears when filing with the Department of Labor, if applicable

Doing Business As (DBA) Name, if applicable *(If your company does business under a different name from that shown above)*:

Street Address	City	State	Zip Code
Billing Address	City	State	Zip Code

Contact Person Name	Phone ( )	Fax ( )

E-mail Address

Type of Business: ❍ Corporation ❍ Partnership ❍ Sole Proprietor ❍ LLC ❍ Other (please specify):	Nature of Business (please be specific):

Federal Tax Identification Number:	Department of Labor Number (if applicable):	General Excise Tax Number:

Current Health Insurance Carrier:	Do you currently have Workers' Compensation Insurance? ❍ YES ❍ NO If yes, name of carrier:

Will those who own 50% or more of the business be enrolled in HMAA's Plan? ❍ YES ❍ NO
If yes, are these owners covered by Workers' Compensation Insurance? ❍ YES ❍ NO If yes, name of carrier (if different from above):

For Businesses with Employees

Requested Effective Date:	Number of Employees to be Enrolled:	Number of Employees Waiving Coverage:
Number of Employees Who Work 20 or More Hours Per Week:	Number of Employees Who Work Less Than 20 Hours Per Week:	Number of Employees Covered by Employer-Sponsored HMO Plan:

Participation Requirements

- ***No co-existence with other Hawaii PPO plans***
- ***If the Business also offers a Hawaii HMO Plan:***
  - *Fewer than 5 Eligible Employees:* *100% HMAA participation required*
  - *5 or More Eligible Employees:* *50% HMAA participation and minimum of 4 employees required*
- ***Employer must retain a copy (updated annually) of Dept. of Labor HC-5 waiver form for all eligible employees waiving employer-sponsored health coverage***

COBRA Information

A completed enrollment application must be submitted for any current COBRA enrollees.

HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

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Business Application

Broker Information

Broker Name	Agency	Date (mm/dd/yy)

Business Certification and Acknowledgement

☐ **I certify the employees enrolling in the plan now and at any time in the future are bona fide employees of this company that receive regular monthly W-2 wages, receive at least the minimum wage required by law, have worked a minimum of 20 hours or more per week for 4 consecutive weeks, and continue to work at least 20 hours per week. I understand that rates are contingent upon meeting the participation requirements noted in this application.**

☐ **I certify the statements and answers contained in this application are complete, true, and accurate.**

☐ **I understand that coverage is subject to rating action and/or rescission and cancellation of coverage for non-disclosure or partial disclosure of the business and on the employee enrollment applications. In addition, any person acting with intent to defraud and/or knowingly aiding another to commit fraud against HMAA is in violation of state and/or federal law and therefore liable for both civil and criminal sanctions. I understand that no coverage is in place until Final Rates are issued and accepted by the Owner or Executive of the Employer. I further understand that I am obligated to immediately report changes to the information contained in this application to HMAA in writing.**

Name of Group/Employer

Owner or Executive Signature   Title

Print Name   Date (mm/dd/yy)

HMAA Association Application

I hereby apply on behalf of my Business for membership in HMAA's Benefits and Services Association, which is a requirement for membership with HMAA.

Signature   Date (mm/dd/yy)